Bureau of Insurance

A Report to the Joint Standing Committee on Insurance and Financial Services of the 121st Maine Legislature

Review and Evaluation of
LD 125, an Act to Promote Fairness and Opportunity for Working Amputees

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I. Executive Summary

The Joint Standing Committee on Insurance and Financial Services of the 121st Maine Legislature directed the Bureau of Insurance to review LD 125, an Act to Promote Fairness and Opportunity for Working Amputees. The review was conducted using the requirements stipulated under 24-A M.R.S.A., §2752 as amended by Public Law 2001, Chapter 258. This review was a collaborative effort of Mercer Risk, Finance & Insurance Consulting, Inc. (Mercer) and the Maine Bureau of Insurance (Bureau).

LD 125 would amend sections of Maine Law pertaining to health policies and HMOs. The bill would require:

- All health plans, at a minimum, must provide coverage and payment for prosthetic devices at least to the extent currently covered under the Medicare program.
- Coverage for repair or replacement of a prosthetic device must be provided.
- A prosthetic device in this bill is defined as an artificial device to replace, in whole or in part, an arm or leg.
- Managed care plans may require that the prosthetic services be rendered by a provider who contracts with the carrier and that a prosthetic device is provided by a vendor designated by the carrier.

The Committee has requested that the analysis be based on the requirement that a prosthetic device is "medically necessary" rather than the language currently in the bill which states that the device "adequately meets the medical needs of the enrollee". Changing the wording to "medically necessary" would be more consistent with the methodology insurance carriers typically use to determine the validity of claims. It is worth noting that the term "medically necessary" has lost some of its impact in managing claims due to lawsuits regarding the subjective nature of the term. This wording may not be sufficient to deny prostheses designed for athletic purposes. Health insurance carriers surveyed have provided alternative wording regarding the eligibility conditions. These suggestions can be found on pages 19 and 20 of the report. Managed care plans may limit the coverage by requiring that the prosthetic services be rendered by a provider who contracts with the carrier and that a prosthetic device is provided by a vendor designated by the carrier.

Some carriers also suggested eliminating the reference to Medicare coverage and payment requirements. We believe this suggestion is worthy of consideration.

In addition, the Committee has requested the study determine the effect on the cost of the proposed mandate if the language were to exclude prosthetic devices specifically designed and used in the course of athletic activities.

We received information regarding existing coverage for prostheses from Anthem, CIGNA, Harvard Pilgrim, United Healthcare Insurance Company (UHIC) and Aetna, all the major insurers in Maine. Most of Anthem's policies contain an unlimited benefit for prostheses. Conversely, most of CIGNA's policies have a $1,000 annual maximum for prostheses. UHIC has an annual $2,500 maximum for durable medical equipment (DME) for small groups. Large groups can purchase different annual maximums or eliminate the maximum entirely. Harvard Pilgrim was unclear regarding their annual maximums. Aetna offers DME benefit annual maximums beginning at $3,000 and ending at unlimited. Most of their group health plans have purchased the unlimited option.

The number of Maine citizens impacted by this bill is very small, only .03% of the non-Medicare population. Of the estimated 850 Maine residents with amputations who choose to wear prostheses, under 100 residents are affected by the annual limitations within their insurance policy. The remaining 750+ non-Medicare residents are served adequately.

The cost for a prosthetic is hard to state generally. It depends very much on the type of amputation, the activity level the individual is capable of and how well the individual adapts to the device. MaineCare estimates that the cost ranges from $4,000 to $40,000. Certain high-tech models such as the Utah Arm cost as much as $70,000 and other high-tech models up to $100,000.

Medicare requires an annual $100 deductible for Part B services, under which prosthetic devices are covered. After the $100 deductible is satisfied, services are covered at 80% of Medicare's allowable charges which historically have been less than actual charges in the market place. Medicare coverage and payment rules are based on medical necessity and physician's orders. Medical necessity, as determined by Medicare, is based on the patient's potential functional ability, which in turn is based upon the treating physician's reasonable expectations regarding the prosthesis and the patient's ability. In addition, Medicare will cover adjustments, repairs and replacements. Medicare has five levels of patient abilities that determine whether prosthesis is medically necessary. Level 0 is defined as the individual not having the ability or potential to ambulate or transfer safely and a prosthesis will not enhance the quality of life or mobility. A Level 4 individual has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills,

exhibiting high impact, stress, or energy levels that are typical of a child, active adult or athlete.

Mercer estimates maximum premium increases attributable to enactment of the proposed mandate in aggregate would be .03%. The impact for any particular group would depend upon its current benefit. Small groups and individuals would see an increase of about .08%, because these benefits are limited in these policies. Large groups would see very little increase because most large groups already have an unlimited benefit. CIGNA estimates cost increases of less than 0.5% and Anthem estimates no material increase. Aetna did not provide an estimate but indicates they would include a .5% margin in their rates especially if prostheses for athletic devices are mandated. UHIC estimates that excluding prosthetic devices specifically designed for athletic devices would cut the costs by half. UHIC estimates for the costs including these devices would be at most $.58PMPM, or a little more than .2% increase to premium. Eliminating the athletic devices would result in a cost of $.33PMPM at the most, or a little over .1%. Harvard estimates the increase in cost would be $.09PMPM, or .03% or premium.

There is very little public data, other than anecdotal, that quantifies the effect of excluding prostheses designed for athletic purposes. CIGNA has estimated that the difference in cost ranges from .04% to .07%. This is not material.

Self-funded plans would not have to comply with LD 125 and therefore would not experience an increase in costs.

II. Background

The Joint Standing Committee on Insurance and Financial Services of the 121st Maine Legislature directed the Bureau of Insurance to review LD 125, an Act to Promote Fairness and Opportunity for Working Amputees. The review was conducted using the requirements stipulated under 24-A M.R.S.A., §2752 as amended by Public Law 2001, Chapter 258. This review was a collaborative effort of Mercer Risk, Finance & Insurance Consulting, Inc. (Mercer) and the Maine Bureau of Insurance (Bureau).

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The Committee has requested that the analysis be based on the requirement that a prosthetic device is "medically necessary" rather than the language currently in the bill which states that the device "adequately meets the medical needs of the enrollee". Changing the wording to "medically necessary" would be more consistent with the methodology insurance carriers typically use to determine the validity of claims. It is worth noting that the term "medically necessary" has lost some of its impact in managing claims due to lawsuits regarding the subjective nature of the term. This wording may not be sufficient to deny prostheses designed for athletic purposes. Managed care plans may limit the coverage by requiring that the prosthetic services be rendered by a provider who contracts with the carrier and that a prosthetic device is provided by a vendor designated by the carrier.

In addition, the Committee has requested the study determine the effect of the cost of the proposed mandate if the language were to exclude prosthetic devices specifically designed and used in the course of athletic activities.

The current insurance law does not have specific requirements for the prosthetic services

to be covered, although Bureau of Insurance Rule Chapter 750 requires all HMO plans to cover durable medical equipment up to at least $2,000 per person in a calendar year, exclusive of any coinsurance or copayments. In most instances, prosthetic services are covered by insurance carriers if the services are medically necessary. However some carriers apply annual and/or lifetime limits on durable medical equipment. This type of limit may impede the beneficiary's ability to purchase or repair the prosthetic device required. The majority of Anthem's policies do not contain any annual maximum on prostheses. CIGNA indicates there is an average annual maximum of $1,000 for all prosthetic on their policies. Aetna indicates most of their group employer plans have unlimited maximums. UHIC requires a $2,500 annual maximum for small groups; large groups can eliminate the maximum.

At the present time, Medicare and Medicaid both cover prosthetic devices provided to their beneficiaries. Medicare requires an annual $100 deductible for Part B services, under which prosthetic devices are covered. After the $100 deductible is satisfied, services are covered at 80% coinsurance of Medicare's allowable charges which historically have been less than actual charges in the market place. Medicare coverage and payment rules are based on medical necessity and physician's orders. Medical necessity, as determined by Medicare, is based on the patient's potential functional ability which in turn is based upon the treating physician's reasonable expectations regarding the prosthesis and the patient's ability. In addition, Medicare will cover adjustments, repairs and replacements. Medicare has five levels of patient abilities that determine whether prosthesis is medically necessary. Level 0 is defined as the individual not having the ability or potential to ambulate or transfer safely and a prosthesis will not enhance the quality of life or mobility. A Level 4 individual has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels that are typical of a child, active adult or athlete. The Medicare Prosthetic Medical Policy from the Medicare Handbook does not appear to address the luxury and/or athletic aspects of the devices.

MaineCare, the state's Medicaid program, also provides coverage for prosthetic services. The program requires the device to be medically necessary. In addition, there are limitations regarding aesthetic or deluxe models. MaineCare does not "pay toward" aesthetic or deluxe models or allow the beneficiary to pay the difference in cost. In addition, MaineCare does provide prosthetic coverage in cases where the private insurance carrier does not pay for the full cost of the devices, but only if the individual qualifies for MaineCare.

Another agency that pays for prosthetic services for Maine residents is the Vocational

Rehabilitation (VR) Program through the Maine Department of Labor, Bureau of Rehabilitation Services. Their goal is to help individuals whose disability has provided a barrier to employment. The VR Program will cover the cost of the prosthetics. In cases where an individual has private insurance coverage, the VR Program will pay the portion not covered by insurance. At the present time, the VR Program has a waiting list of approximately 1,000 individuals.

Currently, two other states, Maryland and Colorado, have adopted laws requiring health insurance companies to cover prosthetic devices for arms or legs. Massachusetts has pending legislation similar to LD 125. In testimony for the support of the Massachusetts proposed legislation, the cost was stated to be $0.07PMPM.[1]

[1] Testimony provided in regard to the Prosthetic Devices Mandate in the State of Massachusetts

III. Social Impact

A. Social Impact of Mandating the Benefit

1. The extent to which the treatment or service is utilized by a significant portion of the population.

This benefit would be used by a very small portion of the population.

Half to three quarters of all amputations are due to disease. A quarter to a third is due to injuries and about five percent are due to tumors. A small number of people are born without limbs and are also referred to as amputees.[2] Most amputations are performed on individuals over the age of 65 or disabled individuals covered by Medicare. Therefore the majority of amputees living in the State of Maine would not be impacted by this legislation. The focus of this report and information provided is for non-Medicare residents.

On average, 80 amputations of lower or upper extremities, excluding toes and fingers, were performed each year from 1999 to 2001 to individuals not covered by Medicare. Of these 80 amputations, 20 were funded by MaineCare, leaving 60 amputations per year funded by commercial insurance.[3] While only 50% of all amputees wear prosthesis, it is reasonable to assume a higher number of new amputees say 90%, will try a prosthesis or 54 individuals.[4]

In addition to the initial purchase of the prosthetic device, there are maintenance, repair and replacements that need to be performed. The average useful life of a prosthetic device is about 3 years.[5]

[2] "A Limb Loss Primer", by Richard L. Mooney, Amputee Resource Center
[3] Maine Health Information Center, www.mhic.org
[4] "Beating Swords into Prosthetic Devices", by Douglas Page
[5] Maine Artificial Limb & Orthotics, www.maineartificiallimb.com

It is estimated there are approximately 1,700 individuals in the State of Maine with amputations of the lower or upper extremities, excluding fingers and toes. This number excludes those individuals covered by MaineCare.[6] As stated previously, only half of amputees choose to wear prosthetic devices, therefore about 850 individuals would require services provided by LD 125.

We estimate that approximately 280 individuals each year would require some type of repair, replacement or adjustment with their current prosthetic device. Taking into account new amputations, the total number of individuals requiring some type of service each year is about 334. Based on 2000 statistics, Maine has approximately 965,000 residents not covered by Medicare or Medicaid.[7] Therefore, approximately .03% of Maine's resident population may be affected by these services described in LD 125.

2. *The extent to which the service or treatment is available to the population.*

Prosthetic devices are readily available locally as well as nationally.

3. *The extent to which insurance coverage for this treatment is already available.*

Most insurance policies cover prosthetic devices under the durable medical equipment (DME) section of the contract. However, approximately 14.5% of individual amputees covered by private insurance (of which some are probably self-funded plans that are not required to comply with the mandate) or less than 100 individuals are subject to annual DME limits.[8] Therefore this bill represents an expansion of benefits to a relatively small percentage of the population.

For policies that have limits, we have observed annual DME limits in Maine that range from $1,000 to $3,000. Many policies cover the costs like other insurance benefits.

[6] Calculation based on National Health Interview Survey, Vital Statistics Report, Series 10, No. 200, nationwide population (without Medicare) and the % of non-Medicare Maine amputations from the Maine Health Information Center
[7] US Census Bureau, "Demographic Profiles: Census 2000"
[8] Maine Artificial Limb and Orthotics

4. *If coverage is not generally available, the extent to which the lack of coverage results in a person being unable to obtain the necessary health care treatment.*

Most insurance policies cover prosthetic devices. In some cases, there is an annual limit on prosthetics or on DME benefits generally. Of the amputations covered by commercial insurance, approximately 14.5% of the individuals are affected by the annual limits placed on DME benefits in the policy.[9] Some of these are probably covered by self-funded plans which do not have to comply with the mandate. An estimated 280 individuals with prior amputations will need repairs and about 54 new amputees will desire prostheses. Only about 48 of these individuals will not have full insurance coverage [(280+54) x .145 = 48] In cases where benefits are limited the individual faces the decision of choosing a lower cost option, paying the difference out of their own pocket, or forgoing prosthetic devices altogether. There may be other options available in some situations.

Another potential source of funding is the VR Program. This agency will cover the cost of prosthetic devices in the event the amputation is a barrier to employment. If an individual has private insurance, this agency will pay the costs not covered by the private insurance. Recently, this agency helped on average about 3 individuals per year. The agency's funding is limited; therefore a waiting list has been established.

Medicare is the largest financial resource for prosthetic care. Medicare covers other equipment such as wheelchairs, walkers and crutches. This may be a viable option for an individual who can become eligible as totally disabled under Social Security Disability (SSD). It is difficult to become qualified (about 70% to 75% of all applicants are initially denied).[10] MaineCare provides coverage for prostheses for qualifying low-income individuals.

The Veterans Health Administration (VHA) provides prostheses, among other devices. The Veterans Administration (VA) also provides prostheses as part of its health care benefits to certain children of Vietnam veterans. The VA health care enrollment is a new system providing access to a comprehensive package of services. There are specific requirements for participation for veterans to qualify.

[9] Maine Artificial Limb and Orthotics

[10] "Financial Assistance for Prostheses and Other Assistive Devices", complied by Mary Jo Walker, National Limb Loss Information Center (NLLIC) information specialist, Living with Limb Difference

Civilian Health and Medical Programs of the Uniformed Services, CHAMPUS, now called TRICARE, provides benefits to dependents of active-duty service members, retirees and their dependents and survivors. TRICARE provides prostheses.

There are now medical discount programs that include the makers of prostheses. These programs involve buying a card that allows the user to enjoy discounts at participating providers. Services include drugs, vision care, prostheses among others. Examples of medical discount programs currently available are: POWERx Medical Benefits Network, HealthCove, Care Entrée. These are not insurance programs, but rather discount programs.[11]

There are several charities that assist in the financing of prostheses. The National Center on Physical Activity & Disability has a list of sources for financial assistance on their website.[12]

5. *If coverage is not generally available, the extent to which the lack of coverage involves unreasonable financial hardship.*

Approximately 14.5% of individuals with amputations are subjected to annual limits on DME benefits. Generally, the plans with limited benefits have limits in the range of $1,000 to $3,000 per year. Since the costs of prosthetic devices can vary from $4,000 to $40,000, and up to $100,000 for the most technologically advanced models it can represent a significant financial hardship to individuals with limited benefits.

[11] "Financial Assistance for Prostheses and Other Assistive Devices"
[12] The website for the NCPAD is www.ncaonline.org

6. *The level of public demand and the level of demand from providers for this treatment or service.*

The rate of Maine amputees is .03% therefore the demand is quite small.

7. *The level of public demand and the level of demand from the providers for individual or group coverage of this treatment.*

Several members of the public testified with regards to LD 125. The Maine Medical association also testified. All who testified were in favor of the bill. No one appeared with opposing or neutral testimony. However the Maine Association of Health Plans wrote in opposition, citing concern over the language in the bill which they interpret as having no limitations on the amount spent on the type of prosthesis covered. Prosthetic devices with bionics can cost nearly $100,000.

Two of the individuals testifying were affected by the DME limits of their health care policy. The proposed bill would significantly impact the financial situation of these individuals.

In another case, the individual lost insurance coverage through work and has not purchased health insurance. In this particular case, MaineCare covered the cost of the prosthetic. LD 125 does not address cases where the individual does not have health insurance coverage.

The other two individuals testifying were not impacted directly by the costs of prosthetic devices and the limits imposed by some insurance companies, but rather were testifying in support of LD 125.

For one individual who testified, we were unable to determine whether LD 125 would impact the individual's coverage.

8. *The level of interest in and the extent to which collective bargaining organizations are negotiating privately for the inclusion of this coverage by group plans.*

No information is available.

9. *The likelihood of meeting a consumer need as evidenced by the experience in other states.*

At the present time, there are only two states, Maryland and Colorado, who have enacted similar legislation. We were not able to obtain information from these states to determine the effectiveness of this legislation. Colorado did not track the effect of the bill. Massachusetts has legislation pending similar to LD 125. In testimony for the support of the Massachusetts proposed legislation, the cost was stated to be $0.07PMPM.[13]

10. *The relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit.*

The Maine Health Information Center analyzed three years of hospital discharge information to determine the extent to which LD 125 would impact the population of Maine. Based on their findings, the most significant population with amputations is the Medicare-eligible individuals. Approximately 77% of all amputations from 1998 to 2001 were covered by Medicare. Only 16% of the amputations were covered by commercial insurance. This translates into an average of sixty individuals per year who were commercially insured.[14]

11. *Alternatives to meeting the identified need.*

As previously discussed, the VR Program provides prosthetic devices to individuals who find their disability an impediment to employment. This program works in combination with the individual's private insurance to provide full coverage. At the present time, this program has a long waiting list. This program could be expanded so that more individuals could be helped each year. This alternative however, would not help those currently employed whose insurance coverage has significant limitations. In addition, this program is

[13] Testimony provided in regard to the Prosthetic Devices Mandate in the State of Massachusetts
[14] Maine Health Information Center

partially funded by the State of Maine and would require additional funding. Maine is currently experiencing a deficit; finding additional funds would be difficult.

Maine Consumer Information and Technology Training Exchange (CITE) provides equipment for qualifying individuals.

Alpha One in Maine provides loans for individuals needing assistance with the purchase of a prosthesis. The individual must be financially able to repay the loan.

There are many charities that will help with the procurement of a prosthesis. There is a list of entities providing financial assistance on the National Center on Physical Activity & Disability (NCPAD) website.[15]

12. *Whether the benefit is a medical or a broader social need and whether it is inconsistent with the role of insurance and the concept of managed care.*

The number of individuals with the need for prosthetic devices is very small. We have estimated that only .03% of the Maine residents would be impacted by this benefit. In addition, there are studies that indicate that only one-third of individuals with below-knee amputations and 80% of those with above-knee amputations choose not to wear prosthetic devices. In addition, 78% of all amputees wear their prostheses less than an hour a day, if at all.[16]

The proposed benefit is not inconsistent with the role of insurance. Over the years, DME benefits have been added to health insurance policies, but often on a limited basis. Presently, group health insurance policies typically cover this type of benefit, however some policies do place an annual limit on these benefits.

The benefit is not inconsistent with managed care. Most managed care plans cover prosthetic devices, albeit limited. In addition, the bill contains language that allows managed care plans to require prosthetic devices be rendered by providers with whom they have contracted.

13. *The impact of any social stigma attached to the benefit upon the market.*

The amputation of a lower or upper extremity will more than likely cause amputees to feel social stigmas at least initially. The use of prosthetic devices will not only allow amputees to better resume normal activities, it may ease the

[15] The National Center of Physical Activity & Disability, www.ncaonline.org
[16] "Beating Swords into Prosthetic Devices"

social stigma amputees may feel. Through the use of a prosthetic device, the amputation may be less noticeable in social settings.

14. The impact of this benefit upon the other benefits currently offered.

Typically, prosthetic devices are covered under the DME section of health insurance policies. For those policies without annual or lifetime limits, this benefit would produce little to no impact on the general DME benefits.

The bill does require the benefit to be covered similar to Medicare, therefore the prosthetic devices would need to be covered at 80%. If the general coinsurance coverage in a health insurance policy is different than 80%, the prosthetic devices could potentially be covered at a different rate. Most policies that have coinsurance also have out of pocket maximums. When the member reaches an out of pocket maximum, all benefits are covered at 100% thereafter. Medicare does not have this feature. Medicare requires an annual $100 deductible for Part B services, under which prosthetic devices are covered. If the deductible in the health insurance policy is different than $100, this benefit would be covered at a different level.

Based on the information provided from insurance carriers in Maine that were surveyed, this would have a minimal impact on the benefits.

For those health plans that have annual limits, the removal of the prosthetic devices from the DME section, would theoretically provide more DME coverage to amputees.

15. *The impact of the benefit as it relates to employers shifting to self-insurance and the extent to which the benefit is currently being offered by employers with self-insured plans.*

It is not anticipated that paying for prosthetic devices at Medicare levels without annual limits would impact premiums sufficiently to cause employers to shift to self-insurance. Self-insured plans probably currently cover prosthetic devices at some level. We do not know the percentage of self-insured plans that place a limit on DME benefits.

State legislation that imposes benefit mandates will heighten an employer's concern with regard to future costs and make self-insurance a more attractive alternative. The 2002 Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans indicates that over 50% percent of the large employers (500 or more employees) in the Northeast self-insure health plans.

16. *The impact of making the benefit applicable to the state employee health insurance program.*

Anthem estimated that LD 125 would not impact the cost of the State Employee Health Insurance Plan unless the bill forced the benefit coverage for the most expensive method of treatment available.

IV. Financial Impact

B. Financial Impact of Mandating Benefits.

1. The extent to which the proposed insurance coverage would increase or decrease the cost of the service or treatment over the next five years.

Mandating an unlimited maximum for payment of prostheses would probably increase the cost of the prostheses over the next five years. It is an accepted insurance maxim that the costs of services increase when there is a third-party payor funding the majority of the costs. This is consistent with the results of a Factiva study which shows that members who perceive a high need for health care will purchase the richest plan, resulting in a third party funding the majority of the costs.[17] This is also consistent with the verbiage on Utah Arm and Motion Control Products website. They indicate that a complete Utah Arm will cost about $50,000 to $70,000 and a ProControl 2 system for below elbow and hybrid prostheses will cost approximately $25,000 to $30,000, "which are covered by most insurance policies including Medicare. If insurance coverage is not available, less expensive alternatives are available."

The increase in costs would also be partially due to improved technology and demand for the best technology. There was testimony given about a cheerleader who has a prosthesis. She said that the mother cannot afford a "top-of-the-line prosthesis, so the girl has to make do with substandard equipment." If all prostheses become "top-of-the-line", the costs will increase significantly. Some prosthetic arms cost $70,000.[18] The current language, "adequately meets the medical needs of the enrollee" may allow for an interpretation for prosthetic devices that are above those determined by the enrollee's provider to be the most appropriate medically necessary model that will allow the member to adequately perform activities of daily living. Medicare's use of "medical necessity" may be more stringent, although the use of "medical necessity" as a means of denying or lowering benefits in the commercial market has rapidly decreased due to litigation. The bill requires that the maximum allowable payment will at least

[17] "Health Plan Choice and Information about Out-of-Pocket Costs: An Experimental Analysis", by Michael Schoenbaum, Mark Spranca, Marc Elliott, Jay Bhattacharya, Pamela Farley, April 1, 2001, Inquiry, Volume 38, Issue 1

[18] Utah Arm website, www.UtahArm.com

equal the Medicare fee schedule. This should help, in part, to minimize the increase in costs.

There is a belief that volume can force costs down. This is true of total hip replacement.[19] However, there were over 128,000 hip replacements in 1994, the base line year. The introduction of prospective payment system for diagnosis related group (DRG) in 1983 provides an incentive to control costs, since the hospital will be paid a flat fee for each hip replacement, regardless of what the actual cost was. This incentive drove hospitals to study their protocols and has resulted in significant reductions. It is highly questionable whether mandated prostheses would experience the same cost reduction. The population for prostheses is very small by comparison. No one wants to have an amputation. This limits the demand. Requiring third parties to pay a significant portion of the total cost would result in the opposite incentive experienced by hospitals and DRGS.

There is also a school of thought that says the average cost of a prosthesis would decrease because part of the provider's pricing covers a certain percentage of bad debts.[20] In our review of websites for companies making prostheses, financing the prostheses is generally the first step in obtaining one. Many companies refer individuals without insurance or with insufficient insurance to charities that help fund the cost.

2. *The extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service over the next five years.*

Statistics show that one-third of below-the-knee amputees do not use any prostheses; 80% of above-the-knee amputees do not use any prosthesis and 78% of those that do use a prosthesis wear it less than one hour a day.[21] It is difficult to determine if these low-utilization-statistics are associated with costs, or with difficulties in adapting to a usable prosthesis. As the technology of prostheses improves, it may be possible that a larger percentage of amputees will take advantage of them. It might not be an appropriate use of very scarce health care dollars if the majority of the prostheses are not used.

[19] "Total Hip Replacement: A Case History", Vicky J. Keston, Alain C. Enthoven, Health Care Management Review, January 1998, Vol. 23, No. 1
[20] Testimony provided in regard to the Prosthetic Devices Mandate in the State of Massachusetts
[21] "Beating Swords into Prosthetic Devices"

3. *The extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service.*

This mandate would probably result in more expensive treatment by providing higher payment for prostheses.

Proponents argue that by providing significant coverage of prostheses, individuals that have this need will continue to be active and self-supporting. Testimony in Massachusetts "estimated that every dollar spent on rehabilitation, including orthotic and prosthetic care, saves more than $11 in disability benefits." There was no source cited in this testimony.

Building Self Esteem indicates that adequate financial resources reduce depression of amputees.[22] Funding of prostheses would aid in the creation of adequate financial resources.

It is extremely important for individuals with amputations of the lower extremities (LE) to exercise. Studies have shown that non-vascular LE amputees have higher rates of cardiovascular disease, hypertension and adult-onset diabetes when compared to the non-disabled population.[23] Pitetti says that it is important for an LE amputee to have a comfortable prosthetic limb(s) that is suited for exercise. Activities that do not require special adaptations to a standard limb are treadmill walking, bicycling, rowing, StairMaster, and other aerobic machines. Having prosthetics that fit should reduce medical costs for the treatment of cardiovascular disease, hypertension and adult-onset diabetes for LE amputees.

4. *The methods which will be instituted to manage the utilization and costs of the proposed mandate.*

Suggestions have been made to include language that would eliminate prostheses for competitive sports as a means of controlling utilization. CIGNA suggested the following:

> "Covered benefits must be provided for a prosthetic device determined by the enrollee's provider to be the most appropriate medically necessary

[22] "Living with Limb Differences", Gail M. Williamson, PhD., associate professor, Department of Psychology, University of Georgia

[23] "Amputation and Exercise", Ken Pitetti, Ph.D., Professor, College of Health Professions, Wichita State University, The National Center on Physical Activity and Disability

model that will allow the member to adequately perform ordinary activities of daily living. For the purposes of this section, "activities of daily living" shall be defined as "self-care activities including, but not limited to, bathing, grooming, dressing, eating and toileting."

CIGNA also suggested a limit of $10,000 every four years which includes repairs and replacements. This limit is inconsistent with the goals of the proposed legislation. CIGNA's health policies generally have an annual limit of $1,000 for all prosthetic devices.

Aetna suggests eliminating the reference to Medicare coverage and payment requirements as well as reference to covering a prosthetic device "determined by an enrollee's provider." Aetna believes the "determined by an enrollee's provider" verbiage is in conflict with the "prior approval" verbiage. Aetna recommends eliminating athletic devices.

UHIC suggests the following:

a) "Rather than require that the coverage be the same as Medicare, simply state that coverage would be subject to the same deductible, copayment, coinsurance and benefit limits as other similar services. It does not make sense to mandate essentially $100 deductible and 20% coinsurance for prosthetic devices if other services are subject to, say, a $500 or $1,000 deductible and 30% coinsurance. Similarly, Medicare Part B has no OOPL (out of pocket limit); it would follow that the plan's normal OOPL also apply to prosthetic devices.
b) Allow a reasonable annual maximum benefit for these devices.
c) Allow carriers to exclude devices designed and used for athletic activities and to limit the purchase of each type of device to one time every year.

In further discussions with UHIC's consulting actuary, the following was suggested:

Limit the number of devices to two in the first twelve months following amputation. For adults a limit of one per year thereafter. This limit is not applicable for a child under eighteen.

Harvard currently excludes athletic devices.

Insurance companies and HMOs may implement guidelines for the frequency of replacement and repairs that are consistent with the goals of the legislation. Medicare has classification levels that may help determine the proper prosthetic. For example, a K0 code indicates that the individual does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility. A K4 code indicates the individual has the ability or potential for prosthetic ambulation that exceed basic ambulation skills, exhibiting high impact, stress or energy levels. This is typical of the prosthetic demands of a child, active adult or athlete.[24]

The proposed legislation allows a carrier to require prior authorization for prosthetic devices in the same manner as prior authorization is required for any other covered benefit.

Managed care plans may require that the prosthetic services be rendered by a provider who contracts with the carrier and that a prosthetic device is provided by a vendor designated by the carrier.

5. *The extent to which insurance coverage may affect the number and types of providers over the next five years.*

Since the number of amputees desiring prostheses is very limited, we do not anticipate a material change in the number or types of providers of prostheses.

6. *The extent to which the insurance coverage of the health care service or provider may be reasonably expected to increase or decrease the insurance premium or administrative expenses of policyholders.*

Anthem currently provides unlimited coverage for prostheses for many of its products and a $3,000 annual maximum for a few. According to Anthem, prostheses claims are $.25 to $.50 per member per month, or .1% to .2% of total claims. Anthem believes this mandate would not have any material impact of its costs.

CIGNA estimates the following increase in costs:

$PMPM

[24] "Financial Assistance for Prostheses and Other Assistive Devices"

PMPM Impact	Large Group HMO	Large Group PPO/Indemnity	Small Group HMO	Individual HMO
Premium	$1.11	$0.50	$0.77	$1.34
Administration	0.09	0.02	0.12	0.12
Premium, excluding athletic	0.89	0.40	0.62	1.07
Admin, excluding athletic	0.07	0.02	0.10	0.17

% of Premium

PMPM Impact	Large Group HMO	Large Group PPO/Indemnity	Small Group HMO	Individual HMO
Premium	0.34%	0.16%	0.21%	0.18%
Administration	0.03	0.01	0.03	0.03
Premium, excluding athletic	0.27	0.12	0.17	0.14
Admin, excluding athletic	0.02	0.01	0.03	0.02

CIGNA was unable to provide the $PMPM for its current benefit, which is generally $1,000 per year. We estimate the value of CIGNA'S current benefit to be $.03 PMPM prior to expenses (.0003 x 1,000 ÷ 12 = .025).

UHIC provided the following cost estimates:

UHIC Estimate Premium Difference Due to Proposed Mandate Assumed No Athletic Devices		
	PMPM Premium Difference	
Current Plan Benefits	**Match Medicare [1]**	**Increase Benefit Only [2]**
$0 deductible, 0% coinsurance	($0.41)	$0.24
$0 deductible, 10% coinsurance, $3,000 OOPL	($0.17)	$0.24
$150 deductible, 0% coinsurance	($0.25)	$0.29
$250 deductible, 10% coinsurance, $2,000 OOPL	$0.05	$0.37
$250 deductible, 20% coinsurance, $2,000 OOPL	$0.18	$0.35
$500 deductible, 20% coinsurance, $2,000 OOPL	$0.33	$0.49

Total	$.04	$.33
[1] Change plan benefit to $100 deductible, 20% coinsurance, no OOPL or maximum benefit.		
[2] No maximum benefit. Deductible and coinsurance are lower of plan's or Medicare's.		

If athletic devices are to be covered, UHIC estimates the costs for these devices to be $.25PMPM

Aetna did not provide an estimate but indicates they would include a .5% margin in their rates especially if prostheses for athletic devices are mandated.

Harvard Pilgrim estimates the cost of this benefit to be $.09PMPM.

7. *The impact of indirect costs, which are costs other than premiums and administrative costs, on the question of the cost and benefits of coverage.*

There would be no additional increase in cost beyond premiums and administrative costs.

8. *The impact on the total cost of health care, including potential benefits and savings to insurers and employers because the proposed mandated treatment or service prevents disease or illness or leads to the early detection and treatment of disease or illness that is less costly than treatment or service for later stages of a disease or illness.*

Statistical data provided by the Maine Coalition of Working Amputees (Coalition) estimate that the number of Maine residents each year impacted by commercial insurance DME maximums is 40, and would cost $125,280. We are unable to replicate their generation of this estimate.

We have developed a range of costs. The traditional actuarial approach calls for an incidence rate, an average cost, and an estimate for expenses. We have estimated that the frequency of amputation is .03%. If we accept the Coalition's estimated cost per prostheses of $5,132, we generate a $PMPM of $.13 prior to an allowance for expenses. If expenses average 12%, the gross cost of adding

prosthetics would be $.15. Even if we assume the cost will increase to $7,500 per prosthesis, the gross cost for prostheses is $.21PMPM. This assumes there is NO coverage currently. Anthem and Aetna indicate almost all of their policies have unlimited benefits. These two insurers represent 71% of the market.[25] Of the other carriers, only CIGNA has a significant market share. We also have to make a slight adjustment in incidence to reflect a higher frequency in demand for prostheses in the first year of amputation. If we assume that CIGNA's benefits are representative of the non-Anthem, non-Aetna market share [which is conservative, since CIGNA has the lowest annual maximum of $1,000] then the average cost would be $.05PMPM prior to consideration of administrative expenses, and $.06 after. This represents .02% of premium.

We also employed a macroeconomic approach. Information prepared by the Maine Health Information Center shows that the average number of amputations for the under 65 population is 85 for the last three years, or which an average of 60 are insured by commercial carriers. If we assume that 90% of the amputees will want a prosthetic device (only 50% of all amputees wear prosthetic devices, but we are assuming a large number of new amputees will try one), we are left with 54 amputees per year. We concur with the Coalition that there will need to be 2 prosthetic devices for new amputees. This means there will be 108 prosthetic devices the first year for these individuals. Only the cost of 14.5% of these devices will experience a limitation, or 16.

The average prosthetic devise lasts 3 years, according to the Coalition. Therefore, there will be another 280 prosthetic devices from previous amputees, of which only 14.5% will experience a limitation for a total of 40 devices each year for previous amputees. The total expected devices each year will be 56 (16 for new amputees and 40 for previous amputees). The average cost of a prosthetic, according to the Coalition, is $5,132. To be conservative, we estimated the cost will be $7,500, reflecting that some individuals may improve the type of prostheses if they do not have to fund the majority of payment. The aggregate cost $370,000. This translates into a $PMPM of $.07 prior to expense consideration and $.08PMPM after expense consideration, or .03% of premium.

As stated earlier, there was testimony in Massachusetts indicating that for every dollar spent on rehabilitation, including orthotic and prosthetic care, saves more than $11 in disability benefits. There was no source cited in this testimony.

[25] Maine Bureau of Insurance

Adequate income facilitates the ability to conduct normal activities which reduce depression.[26] Funding of a significant portion of prosthesis would add to the income of individuals missing limbs. However, due to the small number of individuals impacted by this legislation, this would not have a material impact on health dollars.

9. *The effects of mandating the benefit on the cost of health care, particularly the premium and administrative expenses and indirect costs, to employers and employees, including the financial impact on small employers, medium-sized employers and large employers.*

The cost to employers would vary by size to the extent that the existing benefit and average age/morbidity varies by size. CIGNA estimates that the cost for large group HMO and individuals would be similar while the cost for large group PPO/indemnity and small group would be lower. The costs as a percentage of premium are very low for all groups, the differences are not material.

Insurers in Maine estimated this mandate would cost between 0% and 0.5%.

We estimate the costs would increase 03% in aggregate. The costs for small groups and individuals, which are more likely to have limitations currently, would increase about .08%, while the cost for large groups with more than 50 employees would increase about .02%.

10. *The effect of the proposed mandate on cost-shifting between private and public payors of health care coverage and on the overall cost of the health care delivery system in this State.*

If the costs of some prostheses that are not currently covered by insurance are being paid in part or total by public funds, then there would be a shift from public to private. Currently MaineCare covers on average 6% of all amputees for individuals under age 65. It is possible that some of this would be transferred to the private sector. MaineCare currently pays about $120,000 for prosthetics for qualified individuals with private insurance. There is another $25,000 for these same individuals that is not covered by insurance or MaineCare. The maximum

[26] "Living with Limb Differences"

amount of cost shifting would be $145,000.[27]

[27] Maine Bureau of Insurance

V. Medical Efficacy

C. The Medical Efficacy of Mandating the Benefit.

1. The contribution of the benefit to the quality of patient care and the health status of the population, including any research demonstrating the medical efficacy of the treatment or service compared to the alternative of not providing the treatment or service.

Returning to normal activities is important for an amputee to adapt to his/her new situation.[28] Having a prosthetic device that fits enables one to continue to exercise, return to normal activities, including work, and continue to contribute to society. Removing the majority of the financial risk of purchasing a prosthetic device would help to reduce depression. It is especially important for diabetics to remain active to lessen effects of their disease.

It is extremely important for individuals with lower extremities (LE) amputations to exercise. Studies have shown that non-vascular LE amputees have higher rates of cardiovascular disease, hypertension and adult-onset diabetes when compared to the non-disabled population.[29] Pitetti says that it is important for an LE amputee to have a comfortable prosthetic limb(s) that is suited for exercise. Activities that do not require special adaptations to a standard limb are treadmill walking, bicycling, rowing, StairMaster, and other aerobic machines. Having prosthetics that fit should reduce medical costs for the treatment of cardiovascular disease, hypertension and adult-onset diabetes for LE amputees.

The number of individuals impacted by this bill is small. For society as a whole, there will be little impact whether this legislation is passed or not. There are alternative sources for funding prostheses, mainly charity and government. If the statistics regarding the use of prostheses do not improve, most of the devices would be used little, if any. For the individuals that do take advantage of the availability of prostheses and use them, their quality of life, via mobility and flexibility, can improve significantly.

[28] "Living With Limb Differences"
[29] "Amputation and Exercise"

2. *If the legislation seeks to mandate coverage of an additional class of practitioners relative to those already covered.*

   a. *The results of any professionally acceptable research demonstrating medical results achieved by the additional practitioners relative to those already covered.*

      This is not applicable since the legislation does not mandate coverage of an additional class of practitioners.

   b. *The methods of the appropriate professional organization that assure clinical proficiency.*

      This is not applicable since the legislation does not mandate coverage of an additional class of practitioners.

VI. Balancing the Effects

D. The Effects of Balancing the Social, Economic, and Medical Efficacy Considerations.

1. The extent to which the need for coverage outweighs the cost of mandating the benefit for all policyholders.

The costs of prostheses vary significantly, up to $100,000 for the most technically advanced, although it is unclear if this prosthesis would be eligible for coverage. Our review of the Medicare fee schedules for Maine indicated that the maximum allowable charge is about $40,000. It is unclear whether Medicare's fees schedule would encompass the entire range necessary for the under 65 population. The average cost assumed by the Maine Coalition of Working Amputees is about $5,100. The personal income per capita in 2000 in Maine is slightly above $25,000.[30] The cost of the average prosthesis is 20% of the personal income per capita. Purchasing a more sophisticated prosthesis, which some require, is out of the reach of most Maine residents, if they must fund most or the entire cost.

2. The extent to which the problem of coverage can be resolved by mandating the availability of coverage as an option for policyholders.

Because several carriers have products with unlimited coverage, there is already an option for policyholders, assuming the health insurance decision maker is fully cognizant of prosthetic benefits.

If this benefit is to be provided as a mandatory offer as opposed to a mandatory benefit, then the costs could be higher because only those who perceive a need will purchase the coverage.

3. The cumulative impact of mandating this benefit in combination with existing mandates on costs and availability of coverage.

[30] US Bureau of Economic Analysis, Survey of Current Business, May 2001

It is not possible to precisely measure the impact of mandated benefits. However, it is possible to estimate an outside limit, the maximum possible increase in health insurance premiums resulting from mandates. Because various mandates apply to different categories of coverage, this maximum likewise varies. The Bureau's estimates of the maximum premium increases due to existing mandates and the proposed mandate are displayed in Table A.

TABLE A – MAXIMUM PREMIUM INCREASES **Current Mandates**			
	Group (more than 20 employees)	**Group (20 or fewer employees)**	**Individuals**
Fee-for-Service Plans	8.01 %	4.38%	2.69%
Managed Care Plans	7.60 %	3.97%	3.30%
LD 125			
Fee-for-Service Plans	.03%	.08%	.08%
Managed Care Plans	.03%	.08%	.08%
Cumulative Impact			
Fee-for-Service Plans	8.04%	4.46%	3.76%
Managed Care Plans	7.63%	4.05%	3.38%

These estimates are based on the estimated portion of claim costs that mandated benefits represent, as detailed in Appendix B. The true cost impact is less than this for two reasons:

1. Some of these services would likely be provided and reimbursed even in the absence of a mandate.

2. It has been asserted (and some studies confirm) that covering certain services or providers will reduce claims in other areas. For instance, covering mental health and substance abuse may reduce claims for physical conditions. Covering social workers may reduce claims for more expensive providers such as psychiatrists and psychologists. Covering chiropractic services may reduce claims for back surgery. Covering screening mammograms may reduce claims for breast cancer treatment.

While both of these factors reduce the cost impact of the mandates, we are not able to estimate the extent of the reduction at this time. While some studies have estimated much higher costs for mandated benefits, these studies were not based on the specific mandates applicable in Maine and therefore are not relevant. There is no direct indication that mandated benefits have impacted the availability of health insurance in Maine.

VII. Appendices

Appendix A: Letter Requesting Study with Proposed Legislation

Appendix B: Cumulative Impact of Mandates

Following are the estimated claim costs for the existing mandates without the reductions:

- ***Mental Health*** (Enacted 1983) – The mandate applies only to groups of more than 20. The amount of claims paid has been tracked since 1984 and has historically been in the range of 3% to 4% of total group health claims. Mental health parity for listed conditions was effective 7/1/96. The percentage had been decreasing in recent years from a high of 4.16% in 1997 to 3.27% in 2000, but increased slightly to 3.33% in 2001. For 2001, this broke down as 3.22% for HMOs and 3.67% for indemnity plans. We assume the same levels going forward. Although it is likely that some of these costs would be covered even in the absence of a mandate, we have no basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent.

- ***Substance Abuse*** (Enacted 1983) – The mandate applies only to groups of more than 20 and does not apply to HMOs. The amount of claims paid has been tracked since 1984. Until 1991, it was in the range of 1% to 2% of total group health claims. This percentage showed a downward trend from 1989 to 2000 when it reached 0.31% and increased slightly to 0.37% in 2001. The decrease was probably due to utilization review, which has sharply reduced the incidence of inpatient care. Inpatient claims decreased from about 93% of the total in 1985 to about 55% in 2001. We estimate substance abuse benefits to remain at about the current level. Although it is likely that some of these costs would be covered even in the absence of a mandate, we have not basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent.

- ***Chiropractic*** (Enacted 1986) – The amount of claims paid has been tracked since 1986 and has been approximately 1% of total health claims each year. However, the percentage increased from 0.84% in 1994 to 1.51% in 2000 ant then decreased to 1.32% in 2001. The level varies significantly between group and individual and between HMOs and indemnity plans. We estimate that going forward. The level will be between it 2000 and 2001 levels as shown in the following table:

	Group		Individual	
	HMO	Indemnity	HMO	Indemnity
2000	1.72%	1.41%	0.88%	0.35%
2001	1.46%	1.28%	0.51%	0.31%
Projected	1.6%	1.35%	0.7%	0.33%

Although it is likely that some of these costs would be covered even in the absence of a mandate, we have no basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent.

- ***Screening Mammography*** (Enacted 1990) – The amount of claims paid has been tracked since 1992. It increased from 0.11% of total claims in 1992 to 0.59% in 2001, which may reflect increasing utilization of this service. The 2001 figure broke down as 0.62% for group HMO plans, 0.58% for group indemnity plans, .54% for individual HMO plans, and 0.33% for individual indemnity plans. We estimate the same levels going forward. Although it is likely that some of these costs would be covered even in the absence of a mandate, we have not basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent.

- ***Dentists*** (Enacted 1975) – This mandate requires coverage to the extent that the same services would be covered if performed by a physician. It does not apply to HMOs. A 1992 study done by Milliman and Robertson for the Mandated Benefits Advisory Commission estimated that these claims represent 0.5% of total health claims and that the actual impact on premiums is "slight." It is unlikely that this coverage would be excluded in the absence of a mandate. We include 0.1% as an estimate.

- ***Breast Reconstruction*** (Enacted 1998) – At the time this mandate was being considered in 1995, Blue Cross and Blue Shield of Maine estimated the cost at $0.20 per month per individual. We have no more recent estimate. We include 0.02% in our estimate of the maximum cumulative impact of mandates.

- ***Errors of Metabolism*** (Enacted 1995) – At the time this mandate was being considered in 1995, Blue Cross estimated the cost at $0.10 per month per individual. We have no more recent estimate. We include 0.01% in our estimate.

- ***Diabetic Supplies*** (Enacted 1996) – Our report on this mandate indicated that most of the 15 carriers surveyed in 1996 said there would be no cost or an insignificant cost because they already provide coverage. One carrier said it would cost $.08 per month for an individual. Another said .5% of premium ($.50 per member per month) and a third said 2%. We include 0.2% in our estimate.

- ***Minimum Maternity Stay*** (Enacted 1996) – Our report stated that Blue Cross did not believe there would be any cost for them. No other carriers stated that they required shorter stays than required by the bill. We therefore estimate no impact.

- ***Pap Smear Tests*** (Enacted 1996) – No cost estimate is available. HMOs would typically cover these anyway. For indemnity plans, the relatively small cost of this test would not in itself satisfy the deductible, so there would be no cost unless other services were also received. We estimate a negligible impact of 0.01%.

- ***Annual GYN Exam Without Referral*** (managed care plans) (Enacted 1996) – This only affects HMO plans and similar plans. No cost estimate is available. To the extent the PCP would, in absence of this law, have performed the exam personally rather than referring to an OB/GYN, the cost may be somewhat higher. We include 0.1%.

- ***Breast Cancer Length of Stay*** (Enacted 1997) – Our report estimated a cost of 0.07% of premium.

- ***Off-label Use Prescription Drugs*** (Enacted 1998) – The HMOs claimed to already cover off-label drugs, in which case there would be no additional cost. However, providers testified that claims have been denied on this basis. Our 1998 report did not resolve this conflict but stated a "high-end cost estimate" of about $1 per member per month (0.6% of premium) if it is assumed there is currently no coverage for off-label drugs. We include half this amount, or 0.3%.

- ***Prostate Cancer*** (Enacted 1998) – No increase in premiums should be expected for the HMOs that provide the screening benefits currently as part of their routine physical exam benefits. Our report estimated additional claims cost for indemnity plans would approximate $0.10 per member per month. With the inclusion of administrative expenses, we would expect a total cost of approximately $0.11 per member per month, or about 0.07% of total premiums.

- ***Nurse Practitioners and Certified Nurse Midwives*** (Enacted 1999) – This law mandates coverage for nurse practitioners and certified nurse midwives and allows nurse practitioners

to serve as primary care providers. This mandate is estimated to increase premium by 0.16%.

- ***Coverage of Contraceptives*** (Enacted 1999) – Health plans that cover prescription drugs are required to cover contraceptives. This mandate is estimated to increase premium by 0.8%.

- ***Registered Nurse First Assistants*** (Enacted 1999) – Health plans that cover surgical first assisting are mandated to cover registered nurse first assistants if an assisting physician would be covered. No material increase in premium is expected.

- ***Access to Clinical Trials*** (Enacted 2000) – Our report estimated a cost of 0.46% of premium.

- ***Access to Prescription Drugs*** (Enacted 2000) – This mandate only affects plans with closed formularies. Our report concluded that enrollment in such plans is minimal in Maine and therefore the mandate will have no material impact on premiums.

- ***Hospice Care*** (Enacted 2001) – No cost estimate was made for this mandate because the Legislature waived the requirement for a study. Since carriers generally cover hospice care already, we assume no additional cost.

- ***Access to Eye Care*** (Enacted 2001) – This mandate affects plans that use participating eye care professionals. Our report estimated a cost of 0.04% of premium.

- ***Dental Anesthesia*** (Enacted 2001) – This mandate requires coverage for general anesthesia and associated facility charges for dental procedures in a hospital for certain enrollees for whom general anesthesia is medically necessary. Our report estimated a cost of 0.05% of premium.

These costs are summarized in the following table:

COST OF EXISTING MANDATED HEALTH INSURANCE BENEFITS

Year Enacted	Benefit	Type of Contract Affected	Est. Maximum Cost as % of Premium	
			Indemnity	HMO
1975	**Maternity** benefits provided to married women must also be provided to unmarried women.	All Contracts	0[31]	0[31]
1975	Must include benefits for **dentists'** services to the extent that the same services would be covered if performed by a physician.	All Contracts except HMOs	0.1%	--
1975	Family Coverage must cover any **children** born while coverage is in force from the moment of birth, including treatment of congenital defects.	All Contracts except HMOs	0[31]	--
1983	Benefits must be included for treatment of **alcoholism and drug dependency**.	Groups of more than 20 except HMOs	0.37%	--
1975 1983 1995	Benefits must be included for **Mental Health Services**, including psychologists and social workers.	Groups of more than 20	3.67%	3.22%
1986 1994 1995 1997	Benefits must be included for the services of **chiropractors** to the extent that the same services would be covered by a physician. Benefits must be included for therapeutic, adjustive and manipulative services. HMOs must allow limited self referred for chiropractic benefits.	Group	1.35%	1.6%
		Individual	0.33%	0.7%
1990 1997	Benefits must be made available for screening **mammography**.	Group	0.58%	0.62%
		Individual	0.33%	0.54%
1995	Must provide coverage for **reconstruction of both breasts** to produce symmetrical appearance according to patient and physician wishes.	All Contracts	0.02%	0.02%
1995	Must provide coverage for **metabolic formula** and up to $3,000 per year for prescribed modified low-protein food products.	All Contracts	0.01%	0.01%
1996	Benefits must be provided for **maternity (length of stay)** and newborn care, in accordance with "Guidelines for Perinatal Care."	All Contracts	0	0
1996	Benefits must be provided for medically necessary equipment and supplies used to treat **diabetes** and approved self-management and education training.	All Contracts	0.2%	0.2%
1996	Benefits must be provided for **screening Pap tests**.	Group, HMOs	.01%	0
1996	Benefits must be provided for **annual gynecological exam** without prior approval of primary care physician.	Group managed care	--	0.1%
1997	Benefits provided for **breast cancer treatment** for a medically appropriate period of time determined by the physician in consultation with the patient.	All Contracts	.07%	.07%
1998	Coverage required for **off-label use of prescription drugs** for treatment of cancer, HIV, or AIDS.	All Contracts	0.3%	0.3%
1998	Coverage required for **prostrate cancer screening**.	All Contracts	.07%	0

[31] This has become a standard benefit that would be included regardless of the mandate

1999	Coverage of nurse **practitioners and nurse midwives** and allows nurse practitioners to serves as primary care providers.	All Managed Care Contracts		0.16%
1999	Prescription drug must include **contraceptives.**	All Contracts	0.8%	0.8%
1999	Coverage for **registered nurse first assistants.**	All Contracts	0	0
2000	Access to **clinical trials.**	All Contracts	0.46%	0.46%
2000	Access to **prescription drugs.**	All Managed Care Contracts	0	0
2001	Coverage of **hospice care services** for terminally ill.	All Contracts	0	0
2001	Access to **eye care**	Plans with participating eye care professionals	0	0.04%
2001	Coverage of **anesthesia** and facility charges for certain **dental** procedures	All Contracts	0.05%	0.05%
Total cost for groups larger than 20:			**8.01%**	**7.6%**
Total cost for groups of 20 or fewer:			**3.97%**	**4.38%**
Total cost for individual contracts:			**2.69%**	**3.30%**

Appendix C: References

Testimony provided in regard to the Prosthetic Devices Mandate in the State of Massachusetts

"A Limb Loss Primer", by Richard L. Mooney, Amputee Resource Center

Maine Health Information Center website, www.mhic.org

"Beating Swords Into Prosthetic Devices", by Douglas Page

Maine Artificial Limb & Orthotics website, www.maineartificiallimb.com

National Health Interview Survey, Vital Statistic Report, Series 10, No. 22

US Census Bureau, "Demographic Profiles: Census 2000"

"Financial Assistance for Prosthesis and Other Assistive Devices", compiled by Mary Jo Walker, Limb Loss Information Center (NLLIC) information specialist, Living With Limb Difference

The National Center on Physical Activity & Disability website, www.ncaonline.org

"Health Plan Choice and Information about Out-of-Pocket Costs: An Experimental Analysis", by Michael Schoenbaum, Mark Spranca, Marc Elliot, Jay Bhattacharya, Pamela Farley, April 1, 2001, Inquiry, Volume 38, Issue 1

Utah Arm website, www.utaharm.com

"Total Hip Replacement: A Case History", by Vicky J. Keston, Alain C. Enthoven, Health Care Management Review, January 1998, Vol. 23, No. 1

"Amputation and Exercise", Ken Pitteti, Ph.D., Professor, College of Health Professionals, Wichita State University, The National Center on Physical Activity and Disability

Maine Bureau of Insurance

US Bureau of Economic Analysis, Survey of Current Business, May 2001

"2002 Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans"

Appendix D: LD 125 Benefit Cost Estimates

Estimate of Impact on Premium

1	Total Number of New Amputees in Maine for the Under 65 Population (average of 1999-2001		85
2	Average Number of New Amputees Paid by MaineCare		19
3	Average Number of New Amputees Paid Self-Pay or "Other"		6
4	Total Number of New Amputees in Maine Paid by Commercial Insurance ((1)-(2)-(3))		60
5	% of New Amputee that will want Prosthetics		90%
6	Total New Amputees wanting Prosthetics (4) x (5)		54
7	Number of Devices per New Amputee		2
8	Total Number of Devices for New Amputees (6) x (7)		108
9	Devices from Previous Amputees		280
10	Total Devices (8) + (9)		388
11	% of Devices Impacted by Insurance Limits		14.5%
12	Total Number of Devices Affected by Law (10) x (11)		56
12	Cost Per Prosthetic		7,500
13	Average Limit		1,000
14	Total Cost After Limit (12) - (13)		6,500
14	Aggregate Cost	$	365,690
15	Estimated Insured Members in Maine		387,000
16	Cost $PMPM	$	0.08
17	Premium in Maine		1,200,000,000
			0.03%
	The number of insured in Maine is estimated by dividing the members for Anthem (220,554) by it market share 57%		